ILLINOIS DEPARTMENT OF CORRECTIONS

Authorization for Release of Offender Information

I hereby authorize _____ to release
Facility

_____
State specific information to be disclosed.

_____

_____

_____
Purpose of disclosure

from the records of _____ _____
ID Number Print Offender's Name

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility

☐ Other: _____

Name: _____
Print Name

Address: _____
Street Address

_____ _____ _____
City State Zip Code

I hereby release and hold harmless, the State of Illinois, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. The consent is valid for 45 days from the date of the signature. I understand that I have the right to revoke this consent in writing at any time during the 45 day period.

Records disclosed may contain confidential medical information including mental health history and treatment, drug and alcohol history, and HIV disease information.

_____ _____
Offender's Signature Date

When patient is a Minor or Incompetent to give consent:

_____ _____ _____
Print Name of Person Authorized to Consent Signature of Person Authorized to Consent Date

Witness:

_____
Print Name and Title

_____ _____
Signature Date

Distribution: Master File

DOC 0109 (Eff. 9/2002)
(Replaces DCA 5666)